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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a BEVERLY HOSPITAL; BELLWOOD MEDICAL CORPORATION, d/b/a BELLWOOD GENERAL HOSPITAL; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a CHICO COMMUNITY REHABILITATION HOSPITAL, d/b/a CHICO COMMUNITY HOSPITAL; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS, d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD; LANCASTER HOSPITAL CORPORATION, d/b/a LANCASTER COMMUNITY HOSPITAL, et al.,

Plaintiffs-Appellees,

v.

KIMBERLY BELSHE, Director of the California Department of Health Services,

Defendant-Appellant.

No. 96-55208

D.C. No. CV-95-04053-JSL

OPINION

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services,
Defendant,

and

KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendant-Appellant.

No. 96-56249
D.C. No.
CV-96-02322-JSL

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services,
Defendant-Appellant.

No. 96-56485
D.C. No.
CV-96-2322-JSL

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

No. 96-56648

D.C. No. CV-03033-JSL

RICHARD GILMORE, M.D.; SARAF PROTAP, M.D.,
Plaintiffs-Appellees,
v.
DONNA E. SHALALA, Secretary of the United States Department of Health and Human Resources,
Defendant,
S. KIMBERLY BELSHE, Director of Health Services,
Defendant-Appellant.

No. 96-56699
D.C. No. CV-96-05564-JSL

RICHARD GILMORE, M.D., individually and on behalf of all those similarly situated; PRATAP SARAF, M.D., individually and on behalf of all those similarly situated,
Plaintiffs-Appellees,
v.
DONNA E. SHALALA, Ph.D., Secretary of the United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

Nos. 96-56745
97-55220
D.C. No. CV-96-05564-JSL

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services,
Defendant-Appellant.

No. 97-55022
D.C. No.
CV-96-03033-JSL

DONALD R. MACPHERSON, JR., as Successor in interest to decedent Christina MacPherson & MacPherson Oil Company Employee Welfare Benefit Plan,
Plaintiff-Appellant,

v.

EMPLOYERS HEALTH INSURANCE,
Defendant-Appellee.

No. 97-55713
D.C. No.
CV-97-00514-JSL

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding

Argued and Submitted
October 6, 1997—Pasadena, California

Filed December 2, 1997

Before: Stephen Reinhardt and A. Wallace Tashima,
Circuit Judges, and Milton I. Shadur, District Judge.*

Opinion by Judge Shadur

SUMMARY

Health/Medicaid/MediCare and Government Assistance

The court of appeals reversed judgments of the district court. The court held that amendments to the Medicare Act in the Balanced Budget Act of 1997 allows a participating state to limit beneficiary enrollment payments under the Medicare Act's cost-sharing provision to the amount by which the state's Medicaid rate exceeds what Medicare has paid.

In § 1396a(n) of the Medicare Act, Congress dealt with persons who are eligible for both Medicare (federal health insurance program for elderly and disabled) and Medicaid (cooperative federal-state program providing matching funds to states that elect to provide medical services to needy persons). Section 1396a(n) describes what the state plans can set up to cover their obligations on behalf of qualified medical beneficiaries (QMBs).

*The Honorable Milton I. Shadur, United States District Judge for the Northern District of Illinois, sitting by designation.

Appellant Secretary of the Department Health and Human Services took the legal position that under § 1396a(n), participating states have the choice to limit their cost-sharing payments for enrollment of QMBs to the amount by which the state's Medicaid rate exceeds what Medicare has paid. This is the interpretation under which California adopted "Medi-Cal," its Medicaid plan.

In a number of federal lawsuits, appellee Beverly Community Hospital Association and other Medicare and Medicaid providers challenged the reading of § 1396a(n) given by the Secretary and appellee Director of the California Department of Health Services. In each case, the district court rejected the Secretary's interpretation that under § 1396a(n), participating states have the choice to limit their payments so that they need not pay the full cost-sharing amount.

While the cases were pending on appeal, Congress passed the Balanced Budget Act of 1997 (BBA). Included in the statute as Act 4714 is a provision that expressly amends § 1396a(n) to adopt the Secretary's position, and expressly applies to pre-enactment state payments that were the subject of litigation pending on the date of enactment. Congress captioned the new provision a "clarification" regarding state liability for Medicare cost-sharing.

The central issue on appeal was whether the BBA requires application of the Secretary's interpretation of the pre-enactment version of the Medicare statute.

[1] It did not matter whether congressional labeling of the new legislation as a "clarification" had to be credited by a court. What was significant was that Congress's characterization reflected its intention to resolve every still-live dispute in the manner specified. The statutory reference to "pending" lawsuits had to be construed as embracing cases undecided at the district court level and actions pending on appeal.

[2] Because Congress has the authority to change the law as to pending cases, its power to clarify the law—to confirm what the law has always meant—follows a fortiori. [3] If Act 4714 were to be characterized as a substantial change in the law, its retroactive application would have posed potential constitutional problems. If it merely clarified what § 1396a(n) was intended to mean, the Medicaid Act never required states to pay cost-sharing in full.

[4] Congress expressly stated as its intention that the new provision in Act 4714 was a "clarification" of the payment rules contained in § 1396a(n). Congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight.

[5] The argument, that § 4714 effected such a substantial change in terms of the government's liability to health care providers that it could not be treated as clarifying § 1396a(n), proceeded from the premise that § 1396a(n)'s meaning was clear enough so as to need no further explanation. That premise ignored the split of authority construing the statute. Clarity is absent from the Medicare and Medicaid statutes.

[6] Section 1396a(n) was particularly resistant to a single interpretation, and particularly in need of clarification. [7] Given the difficulty that courts have had in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of § 1396a(n) was worthy of real deference.

[8] Act 4714's provisions are a statement of what § 1396a(n) meant all along. That mooted all constitutional objections to the new legislation because they rested on the assertedly retroactive nature of Act 4714.

[9] Any claim that California was violating the new federal statute represented the basis for a new lawsuit. Any such claim called for the generation of a new record, against which

the trial court could determine whether there was anything to the contention that Act 4714's clarification of prior law somehow rendered invalid the Medi-Cal reimbursement methodology for hospitals. The trial court would also have to determine whether that argument might have been forfeited by not raising it the first time around.

COUNSEL

Beverly v. Belshe

Laurie R. Pearlman, California Attorney General, Los Angeles, California, for the defendant-appellant.

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Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C.; Sanford E. Pitler, Bennett & Bigelow, D.S., Seattle, Washington, for the amicus.

CAA v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C., for the defendants-appellants.

William J. Bush, Hanson, Bridgett, Marcus, Vlahos & Rudy, LLP, San Francisco, California, for the plaintiffs-appellees.

Gilmore v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein,

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OPINION

SHADUR, District Judge:

We address here a question of first impression, not only in this Circuit but (understandably in light of the recency of the legislation involved) in any court: whether a congressional enactment adopted in August 1997, but stating that it is retroactive and applicable to pending cases, calls for approval of the reading that has been given to the pre-enactment version of the same legislation by the Secretary of the United States Department of Health and Human Services ("Secretary"). Because we answer that question in the affirmative, we reverse all three decisions below.[1]

All three of these sets of appeals pose a common problem: whether the State of California may choose to limit certain payments, as required by statute to be made to enroll poor people—qualified Medicare beneficiaries ("QMBs")—in the Medicare insurance program, to the amount by which California's Medicaid rate exceeds what Medicare has paid. Those payments, required from all participating states under the Medicaid Act, extend to deductibles, coinsurance and copayments that the QMBs cannot bear fully and that the State is

[1]In each instance the jurisdiction of the district court was based upon 28 U.S.C. §1331. All three judgments are appealable pursuant to 28 U.S.C. §1291.

required to pay on their behalf (whether totally or in part is at stake in these cases).

Title XVIII of the Social Security Act (the "Medicare Act," 42 U.S.C. §§1395-1395ccc[2]) provides a federal health insurance program for elderly and disabled persons. Medicare Part A covers inpatient hospital services and certain related benefits (Sections 1395c-1395i-4), and it is provided automatically for individuals entitled to Social Security retirement or disability benefits (Section 426). Medicare Part B is a voluntary program under which Medicare-eligible persons can obtain supplemental insurance for various outpatient services from physicians and other providers (Sections 1395j-1395w-4). It is financed by a combination of federal funds and premiums paid by or on behalf of eligible individuals (Sections 1395r, 1395t(g)). Both Medicare Part A and Medicare Part B call for payments by covered individuals that constitute the deductibles, coinsurance and copayments referred to earlier.

Title XIX of the Social Security Act (the "Medicaid Act," Sections 1396-1396v) is a cooperative federal-state program that provides federal matching funds to states that elect to provide medical services to certain needy individuals (see Section 1396; *Harris v. McRae*, 448 U.S. 297, 301 (1980)). Although states are not required to participate in Medicaid, if they elect to do so they must follow federal guidelines (*Harris*, 448 U.S. at 301) and must submit for Secretary's approval their state plans that describe the states' intended means for insuring compliance with those guidelines (Section 1396a(b)).

What is at issue in these three sets of appeals is the area of overlap between the Medicare and Medicaid Acts where coverage for the elderly poor is involved. Those persons are often

[2]All further citations to Title 42 provisions will take the form "Section —," utilizing the Title 42 numbering system rather than the internal numbering of the Acts involved.

entitled to participate in such coverage but may not be able to afford to pay the required deductible and coinsurance amounts under Medicare Part A or the premiums and payments needed to enroll in Medicare Part B. At the time that the various lawsuits were filed below, Congress had dealt with individuals who are eligible for both Medicare and Medicaid (see Section 1396d(p)(1)) by stating in Section 1396a(n) of the Medicaid Act what the state plans could set up to cover their obligations on behalf of the QMBs involved.

Three types of plaintiffs (now appellees) are involved in these appeals. *Beverly Hospital* is a class action on behalf of all California hospitals that provide inpatient hospital services under the Medicare and Medicaid Acts. *California Ambulance* involves two types of associations, California Ambulance Association and physician associations including California Medical Association, each type of association also representing providers of services under the two statutes. And *Gilmore* was brought by two doctors who provide outpatient physician services to persons under the two statutes.[3] Thus *Beverly Hospital* involves Medicare Part A, while *California Ambulance* and *Gilmore* implicate Medicare Part B.

Secretary is an appellant in all of the cases except for *Beverly Hospital*, in which she was given leave to participate as an amicus curiae. Director S. Kimberly Belshe of the California Department of Health Services ("Director") is an appellant in all of the cases. Both appellants subscribe to Secretary's legal position pursuant to which California adopted its Medicaid state plan ("Medi-Cal"), which position asserts that under Section 1396a(n) participating States such as California have the choice to limit their payments as described earlier, so that they need not pay the *full* cost-

[3]Although the *Gilmore* case was originally intended to be a class action, any need for class certification was obviated when defendants agreed that the result in the case would be followed as to all persons providing such services.

sharing amount. In each of the cases before us the District Court rejected that contention, as have all four Courts of Appeals that have addressed the question: *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994)("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994)("*Haynes*"); *Pennsylvania Med. Soc'y v. Snider*, 29 F.3d 886 (3d Cir. 1994)("*Snider*"); and *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992)("*Perales*").[4]

After the scheduled briefing of these appeals had been completed, Congress entered the picture. Its Balanced Budget Act of 1997 ("Act"), signed into law by the President on August 5 of this year, included as Act §4714 a provision that expressly amends Section 1396a(n) to adopt the position advanced by Secretary and Director here:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
>
> (3) In the case in which a State's payment for

[4]Although this does not affect our resolution of these cases in light of what follows, it is worth noting that those four Courts of Appeals have employed divergent approaches (reading the statute differently) in reaching their conclusions. And it may be added that those four decisions (and the decisions now on appeal) do not at all reflect a unanimous judicial reaction: For example, two recent District Court decisions, *Dameron Physicians Med. Group v. Shalala*, 961 F.Supp. 1326 (N.D. Cal. 1997) and *Kulkarni v. Leean*, No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23), have joined other lower court decisions going the other way. See also the discussion of the problem at 66 U.S.L.W. 2233 (Oct. 21, 1997).

> medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—
>
> > (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
> >
> > (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
> >
> > (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
>
> This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

There is no dispute among the litigants that if this new statutory provision (which Congress has captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") is applicable, it requires the reversal of the District Court's decisions. One minor variant exists: Beverly Hospital contends that a remand is necessary because Secretary's methodology,

as applied to that hospital's situation, does not mesh with the new enactment. We speak briefly to that question later.

Because Congress was deliberately targeting what were known to be existing disputes on this subject, Act §4714(c) went on to prescribe a retroactive effective date of the quoted amendment:

> (c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act[6] and that is pending as of, or is initiated after, the date of the enactment of this Act.

That being the case, the relevant considerations in our three cases have shifted from those that had occupied the parties' entire scheduled briefing, which (as stated earlier) had been completed before the congressional enactment. We therefore invited and received supplemental briefing on the effect of Act §4714 on these cases. And having done so, we eschew any analysis of those original arguments and turn instead to the validity and applicability of the August 1997 enactment.

Standard of Review

Both because constitutional questions are at issue and

[6]Those cited sections of the Social Security Act respectively correspond to Sections 1396a(n) and 1396(d) in the Title 42 usage employed in this opinion. Those sections are in fact the statutory provisions involved in these appeals.

because the cases come up on summary judgment, we engage in a de novo review of the district courts' final judgments (*Gray v. First Winthrop Corp.*, 989 F.2d 1564, 1567 (9th Cir. 1993) ("The constitutionality of a statute is a question of law which we review de novo"); *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1047 (9th Cir. 1995) (holding that an order granting summary judgment is reviewed de novo)). Each of the issues before us will be examined through that lens.

Application of Act §4714

[1] At the outset we examine the coverage of these appeals by the new legislation—a matter that was challenged in the appellees' briefs but was not addressed by their counsel during oral argument. As the earlier-quoted Act §4714(c) states, the new amendments apply to any payments by a State for items and services furnished pre-enactment as long as the payment "is the subject of a lawsuit...that is pending as of... the date of the enactment of this Act." In that respect it does not matter whether the congressional labeling of the new legislation as simply a "clarification" has to be credited by a court (a subject that we deal with in a moment). What is instead significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation. Hence the statutory reference to "pending" lawsuits must be construed as embracing not only undecided cases at the District Court level but also actions pending on appeal, such as the ones before us.

[2] We have previously ascribed precisely that meaning to the term "pending" in *Gray*, 989 F.2d at 1571. There we cited and quoted from numerous earlier decisions upholding Congress' power to impact the results in cases still "pending" on appeal without running afoul of separation of powers principles:

> These cases are properly construed as "pending" cases for separation of powers purposes. *See Griffith*

> *v. Kentucky*, 479 U.S. 314, 321 n.6, 107 S.Ct. 708, 712 n.6, 93 L.Ed.2d 649 (1987)(judgment is "final" and case is no longer pending only after "the availability of appeal [is] exhausted, and the time for a petition for certiorari [has] elapsed or a petition for certiorari finally [has been] denied"); *see also Georgia Ass'n of Retarded Citizens v. McDaniel*, 855 F.2d 805, 813 (11th Cir. 1988)("When it so intends, [Congress'] ability to affect the content of a nonfinal judgment in a civil case, through retroactive legislation ceases only when a case's journey through the courts comes to an end."), *cert. denied*, 490 U.S. 1090, 109 S.Ct. 2431, 104 L.Ed.2d 988 (1989); *de Rodulfa v. United States*, 461 F.2d 1240, 1253 (D.C. Cir.)("[T]he suit is pending until the appeal is disposed of, and until disposition any judgment appealed from it is still *sub judice*.") (internal quotations omitted), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed.2d 220 (1972).

And what *Gray*, *id.* then said, albeit in the different context of a change in a statute of limitations, applies with equal force to give identical content to the word "pending" in Act §4714(c):

> Because none of the cases here have completed their journey through the appellate process, Congress has the authority to change the underlying substantive law by altering the statute of limitations in a way that affects those pending cases.

Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

[3] That being the case, the next line of inquiry is whether the new enactment is valid in its application to such pending cases. On that score a key threshold issue is whether the

enactment was truly a "clarification" of the prior statute (as Congress said), or was instead a substantial change in the law. If Act §4714 were to be characterized in the latter fashion, its retroactive application would pose a series of potential constitutional problems. If however Act §4714 merely clarifies what Section 1396a(n) was originally intended to mean, then the Medicaid Act never required states such as California to pay cost-sharing in full. In that event the only function of Act §4714 in this situation is to state more clearly what the law already was—it has no retroactive effect that might be called into constitutional question. Because appellees do not dispute the constitutionality of the prospective application of Act §4714, if that provision merely clarifies Section 1396a(n) there are also no potential constitutional problems with the application of the enactment to these pre-Act cases.

[4] As already indicated, Congress expressly (and formally) stated as its intention that the new provision in Act §4714 was a "clarification" of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic (as demonstrated by *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 & n.8 (1969) and earlier cases cited there) that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight (see most recently *Loving v. United States*, 116 S. Ct. 1737, 1749 (1996), quoting the *Red Lion* language as earlier repeated in *Consumer Product Safety Comm'n v. GTE Sylvania*, 447 U.S. 102, 118 n.13 (1980); and see also the plurality opinion in *United States v. Winstar Corp.*, 116 U.S. 2432, 2463 (1996)(speaking in terms of "significant weight")).

Other cases that question the competence of a later Congress to opine on the intended meaning of an earlier statute are readily distinguishable. All of those cases have involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments (*United States v. South-*

western Cable Co., 392 U.S. 157, 170 (1967), rejecting the use of congressional opinions contained solely in House Committee Reports; *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979), rejecting the use of congressional opinions expressed only in Senate Report; and see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40 (1988), rejecting the use not only of a later House Committee Report but also of the later enactment as such as bases for inferring the intent of an earlier Congress). By contrast, here Congress has formally declared Act §4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports.[6] Such formal legislative action squarely fits the *Red Lion* mold as so often (and so recently) reconfirmed by later cases, so that Act §4714 is entitled to great weight in construing the meaning of Section 1396a(n).

[5] Appellees contend that Act §4714 effected such a substantial change in federal law in terms of the government's liability to health care providers that it cannot be treated as simply clarifying Section 1396a(n). But that argument proceeds from the premise that Section 1396a(n)'s meaning was clear enough so as to need no further explanation. Not only does that premise ignore the split of authority construing the statute (though to be sure the four Court of Appeals opinions have uniformly rejected Secretary's reading), but even more significantly any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes (thus even one of the cases relied on by appellees, *Kozlowski*, 42 F.3d at 1450, has pungently—and accurately—characterized the provisions detailing Medicaid and Medicare

[6]While titles of acts are not part of the law, they can be used to resolve ambiguity in a statute, so long as they do not contradict the actual text (see, e.g., *INS v. National Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 189 (1991) and cases cited there). In this instance the congressional title, rather than merely resolving an ambiguity, parallels the provision in Act §4714(c) that specifically makes the statute applicable to pre-Act services involved in pending litigation.

financing as "among the most completely impenetrable texts within human experience").

[6] Section 1396a(n) is a superb example of the baffling nature of the statute. It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification. While one battle has raged (with mixed results) over whether to accept Secretary's construction of the provision, even the courts that have rejected Secretary's approach have not expressed a single construction of the statute (compare *Kozlowski*, 42 F.3d at 1454, reading Section 1396a(n) to allow a state to exercise the option to pay more for a QMB than for a dual-eligible person; *Perales*, 954 F.2d at 859, stating "it appears that the reason that section a(n) authorizes payment beyond the Medicare amount, when it is required by another section, is to clarify that the Medicaid Act does not prohibit a provider from accepting more than the Medicaid rate"; and *Snider*, 29 F.3d at 895, holding that Section 1396a(n) "authorizes the states to deviate from their schedules or payment methods with respect to QMB Part B cost-sharing payments, thus carving out an exception to the general requirement to comply with the Medicaid fee schedules or payment methods"). Only *Haynes*, 36 F.3d at 1076, by following the interpretation established in *Snider*, avoids the spectre of four Courts of Appeals reaching the same result for four (rather than three) different reasons. Congress noted the existing confusion when it made the statement (really an understatement) that the amount that states were required to pay on behalf of QMBs was "the subject of some controversy" (H. Conf. Rep. No. 105-217, 143 Cong. Rec. H6252 (daily ed. July 29, 1997)).

[7] Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference. Appellees' arguments that Act §4714 is new law, despite Congress' unambiguous title for that section, cannot

override that deference, because those arguments incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before Act §4714 was adopted.

[8] We therefore honor Congress' "clarification" label and accept Act §4714's provisions as a statement of what Section 1396a(n) has meant all along. That moots all of appellees' constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of Act §4714. But it is worth adding that we have, en route to our decision, carefully explored the litigants' arguments both as to the pre-Act version of Section 1396a(n) and as to the constitutional issues raised by appellees if Act §4714 were to be viewed as a retroactive change in, rather than a declaratory clarification of, the prior law—questions implicating the separation of powers, the Contract Clause and the Due Process Clause. And that exploration, which necessitated an effort on our part to parse the intricate and complex provisions of the pre-Act legislation, has only deepened our conviction that Congress' stated intention of clarifying that pre-existing law should be credited.

That leaves only one tag end for discussion, a statutory claim raised by the plaintiff Association in No. 96-55208 ("Beverly") that is unique to it as a provider of inpatient medical services to QMBs under Medicare Part A. Beverly argues in its supplemental brief that Medi-Cal's methodology for reimbursing hospitals for their Medicare expenses under Part A is not legal under either Beverly's or Secretary's interpretation of Act §4714(a)(2). Beverly urges this Court to affirm the district court's ruling below on that ground (under the familiar principle, as repeated in *Herrig v. FDIC*, 82 F.3d 282, 284 (9th Cir. 1996), that an appellate court may uphold a ruling on any basis that the record supports, even if it was not considered by the lower court).

But before an appellate court will consider such an issue, ordinarily the argument must have been raised sufficiently for

the trial court to rule on it (*A-1 Ambulance Serv. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir. 1996), citing *In re E.R. Fegert Inc.*, 887 F.2d 955, 957 (9th Cir. 1989)). In this instance Beverly initially cited a single excerpt from the trial court record that it said had raised the statutory issue about Medi-Cal's Medicare Part A reimbursement policies. But post-argument its counsel has clarified its position as presenting a different assertion: that its current argument could not have been made below because it arose only as a result of standards set forth in the later-enacted Section 4714(a)(1), now codified as Section 1396a(n)(2).

[9] We need not resolve that newly-raised contention, nor does it call for a remand rather than a reversal. Any claim that California is violating the new federal statute—something that is necessarily not encompassed within the scope of the record as it was presented to the trial court and is thus not on review in the appeal before us—really represents the basis for a new lawsuit. Any such claim would call for the generation of a new record, against which a trial court could determine in the first instance whether there is anything to the contention that Act §4714's clarification of the prior law somehow renders the Medi-Cal reimbursement methodology for hospitals under Medicare Part A invalid. And in that respect the trial court would also have to determine whether despite the existence of the new enactment, Beverly's argument on that score is one that it could perhaps have raised the first time around, so that it might be held to have forfeited the argument by virtue of its not having done so in this original litigation.

Conclusion

For the reasons that we have stated here at some length, we conclude that Act §4714 is a clarification of the original intent of Congress when it passed Section 1396a(n). That being the case, the district courts' orders granting summary judgment in favor of each appellee are REVERSED. As a final point, we note that Director Belshe has not requested a remand in order

to seek to recoup any excessive payments made pursuant to the district court's orders. We indicate no view as to her right to obtain any such relief.

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

MAR - 3 1998

Cathy A. Catterson, Clerk

U.S. Court of Appeals

BEVERLY COMMUNITY HOSPITAL ASS'N,	)	No 96-55208
Plaintiff-Appellee,	)	D.C. No. CV-95-4053 JSL
v.	)	**ORDER**
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services,	)	
Defendant-Appellant.	)	
CALIFORNIA AMBULANCE ASS'N, CALIFORNIA MEDICAL ASS'N, et al.,	)	Nos. 96-56249 96-56485 96-56648 97-55022
Plaintiffs-Appellees,	)	
v.	)	D.C. Nos. CV-96-2322-JSL CV-96-3033-JSL
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,	)	
Defendants-Appellants.	)	

RICHARD GILMORE, et al.,	)	Nos. 96-56699
Plaintiffs-Appellees,	)	96-56745
	)	97-55713
v.	)	97-55220
	)	
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,	)	D.C. Nos. CV-96-5564-JSL
Defendants-Appellants.	)	

Before: REINHARDT and TASHIMA, Circuit Judges, and SHADUR, District Judge.**

The panel has voted to deny the petitioner for rehearing and to reject the suggestions for rehearing en banc. The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestions for rehearing en banc. Fed. R. App. P. 35(b).

The petitions for rehearing are denied and the suggestions for rehearing en banc are rejected.

** The Honorable Milton I. Shadur, Senior United States District Judge for the Northern District of Illinois, sitting by designation.

ENTERED
CLERK, U.S. DISTRICT COURT

JUL 25, 1996

Central District of California
By _____ Deputy

FILED
CLERK, U.S. DISTRICT COURT

JUL 23, 1996

Central District of California
By _____ Deputy

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

CALIFORNIA AMBULANCE ASSOCIATION, Plaintiff, v. DONNA SHALALA, ET AL., Defendants	CV96-2322 JSL JUDGMENT

The motion of plaintiff California Ambulance Association for summary judgment came for hearing regularly on July 22, 1996. Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law, IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

(1) The motion for summary judgment of plaintiff California Ambulance Association is GRANTED;

(2) Under the federal Medicare and Medicaid Acts, including, but not limited to, 42 U.S.C. §§1396a(a)(10)(E), 1395(d)(p)(1) and 1396d(p)(3), plaintiff's members who provide

medical services to qualified medicare beneficiaries are entitled to compensation for such services at 80% of the allowable medical rate plus full Medicare cost-sharing amounts;

(3) That the amount of such cost-sharing is not limited by the Medi-Cal reimbursement rate for such services;

(4) Section 14109.5 of the California Welfare & Institutions Code and implementing bulletins or regulations insofar as they purport to limit the payment of Medicare cost-sharing for Part B services to QMBs to the Medi-Cal reimbursement rate, violate the Medicare and Medicaid Acts including, without limitation, 42 U.S.C. §1396(a)(10)(E) and the rights of plaintiff and its members under 42 U.S.C. §1983;

(5) That the California Medicaid State Plan and Section 3490.14 of the State Medicaid Manual are invalid to the extent that they purport to limit payment of Medicare cost-sharing for Part B services to QMBs only to the extent that such cost-sharing plus the 80% Medicare payment does not exceed the Medi-Cal reimbursement rate.

(6) Plaintiff is entitled to injunctive relief restraining S. Kimberly Belshe from continuing to execute and implement California Medi-Cal programs to the extent that said program limits the payment of the services of plaintiff's members to QMBs to a sum that does not exceed the Medi-Cal reimbursement rate, said injunctive relief will be effective as of July 23, 1996.

(7) Plaintiffs are entitled to their attorneys' fees and costs under 42 U.S.C. §1988.

While the Court considered independently all of the issues

presented in this case, it adopts the comprehensive analysis of these very same arguments in New York City Health and Hospital Corp. v. Perales, 54 F.2d 854 (2nd Cir. 1992), Pennsylvania Medical Society v. Snider, 29 F.3d 866 (3rd Cir. 1994), and Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11 Cir. 1994). It also adopts the similar reasoning in Rehabilitation Association of Virginia v. Kozlowski, 42 F.3d 144 (4th Cir. 1994), except for that court's construction of the phrase "eligible individuals who are not qualified medicare beneficiaries" in §42 U.S.C. 1396 (n), an issue which the Court find unnecessary to determine in order to reach its decision. The Court, in the present case and in Beverly Community Hospital Association v. Belshe, CV95-4053 (C.D.Cal. Dec. 18, 1995), finds itself in accord with the four Circuits in determining that the government's statutory construction would render the provisions of the Medicare and Medicaid internally inconsistent and undermine the Congressional purposes of the provisions in question.

IT IS SO ORDERED.

Dated:_____

/s/
J. Spencer Letts
United States District Judge

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Attorneys for Plaintiffs

FILED
CLERK, U.S. DISTRICT COURT
SEP 16, 1996
Central District of California
By_____ Deputy

ENTERED
CLERK, U.S. DISTRICT COURT
SEP 18, 1996
Central District of California
By_____ Deputy

LODGED
CLERK, U.S. DISTRICT COURT
AUG 16, 1996
Central District of California
By_____ Deputy

IN THE UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

CALIFORNIA MEDICAL ASSOCIATION, et al,	No. CV96 3033 JSL (JRx)
Plaintiffs,	~~[PROPOSED]~~ ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT
vs.	
DONNA SHALALA, Secretary of United States Department of Health,	
Defendants.	

The motion of plaintiffs California Medical Association, California Academy of Family Physicians, California Society of Anesthesiologists, California Urological Association, California Chapter of the American College of Emergency Physicians,

California Chapter of the American College of Cardiology, California Society of Internal Medicine, California Society of Physician Medicine and Rehabilitation, California Radiology Society, and Chapter of the American College of Radiology, for partial summary judgment came on regularly before the above-entitled court on July 22, 1996. Hanson, Bridgett, Marcus, Vlahos & Rudy by William J. Bush appeared on behalf of plaintiff California Medical Association. California Attorney General by Charlton G. Holland, III appeared on behalf of defendant S. Kimberly Belshe as Director of the California Department of Health Services. The United States Attorney by Russell W. Chittenden appeared on behalf of defendant Donna Shalala, as Secretary of United States Department of Health and Human Services.

The Court having read and considered plaintiffs' moving papers and defendants' opposition thereto, and on the basis of the uncontroverted facts presented in support of said motion and good cause appear therefor,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

1. Plaintiffs' motion for summary judgment is granted.

2. Under the federal Medicare and Medicaid Acts including, but not limited to, 42 U.S.C.§§1396a(a)(10)(E), 1394(d)(p)(1) and 1396d(p)(3), plaintiffs' members who provide physician services to qualified medicare beneficiaries are entitled to compensation for such services at 80% of the allowable medical rate plus full Medicare cost-sharing amounts.

3. That the amount of such full cost-sharing is not limited by the Medi-Cal reimbursement rate for such services.

4. Section 14109.5 of the California Welfare & Institutions Code and implementing bulletins or regulations insofar as they purport to limit the payment of Medicare cost-sharing for Part B services to QMBs to the Medi-Cal reimbursement rate, violate the Medicare and Medicaid Acts including, without limitation, 42 U.S.C. §1396a(a)(10)(E) and the rights of plaintiffs and their members under 42 U.S.C. §1983.

5. That the California Medicaid State Plan and Section 3490.14 of the State Medicaid Manual are invalid to the extent that they purport to limit payment of Medicare cost-sharing for Part B services to QMBs only to the extent that such cost-sharing plus the 80% Medicare payment does not exceed the Medi-Cal reimbursement rate.

6. Plaintiffs are entitled to injunctive relief restraining defendant S. Kimberly Belshe from continuing to execute and implement California Medi-Cal programs to the extent that said program limits the payment of the services of plaintiff's members to QMBs to a sum that does not exceed the Medi-Cal reimbursement rate, said injunctive relief will be effective as of September 9, 1996.

7. Plaintiffs are entitled to their attorneys' fees and costs under 42 U.S.C. §1988.

Dated: September 16, 1996.

/s/ J. Spencer Letts
Judge of the U.S. District Court

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

I. UNITED STATES CONSTITUTION

II. Article I, §10

No State shall . . . pass any . . . Law impairing the Obligation of Contracts . . . .

III. Article III

Section 1. The judicial power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. . . .

Section 2. The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority . . . .

IV. Fifth Amendment

No person shall . . . be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATUTES

Title 42 U.S.C. §1396a(a)(10)(E)(i)

A State plan for medical assistance must . . .

(10) provide—

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title; . . . except that . . . (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and section 1396o(b).

Title 42 U.S.C. §1396a(a)(15) [repealed Pub.L. 100-360, Title III, §301(e)(2)(c) as added by Pub.L. 100-485, Title VI, §608(d)(14)(I)(iii), Oct. 13, 1988, 102 Stat. 2416]

STATE PLANS FOR MEDICAL ASSISTANCE

§1396a(a) A State plan for medical assistance must—

. . .

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide—

(A) for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such title; and

(B) where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to any such individual under the insurance program established by part B of such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources.

Title 42 §1396a(n) Payment Amounts [Pre-1997 Balanced Budget Act]

(n) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

Title 42 U.S.C. §1396d(p) [Pre-1997 Balanced Budget Act]

Qualified medicare beneficiary; medicare cost sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395I-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395I-2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

. . .

(3) The term "medicare cost-sharing" means the following cost incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395I-2 or 1395I-2a of this title; and

(ii) premiums under section 1395r of this title.

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395l(b) of this title).

(D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent."

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

Balanced Budget Act Of 1997

Sec. 4714. Medicaid Payment Rates for Certain Medicare Cost-Sharing

(a) Clarification Regarding State Liability for Medicare Cost-Sharing

(1) In General. Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting "(1)" after "(n)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual."

(2) Conforming Clarification. Section 1905(p)(3) (42 U.S.C. §1396d(p)(3)) is amended by inserting "(subject to section 1902(n)(2))" after "means."

(b) Limitation on Medicare Providers

(1) Provider Agreements. Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose any charge that is prohibited under section 1902(n)(3)."

(2) Nonparticipating Providers. Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section."

(c) Effective Date. The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

California Welfare & Institutions Code §14109

Determination of medical needs; inclusion of cost of deductibles or cost sharing charge

In determining the needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age of over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

V. California Welfare & Institutions Code §14109.5

Limitation on reimbursement rate notwithstanding inclusion of cost of deductibles or cost sharing charge; change orders; expeditious implementation

Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this

chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates estab-lished under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.

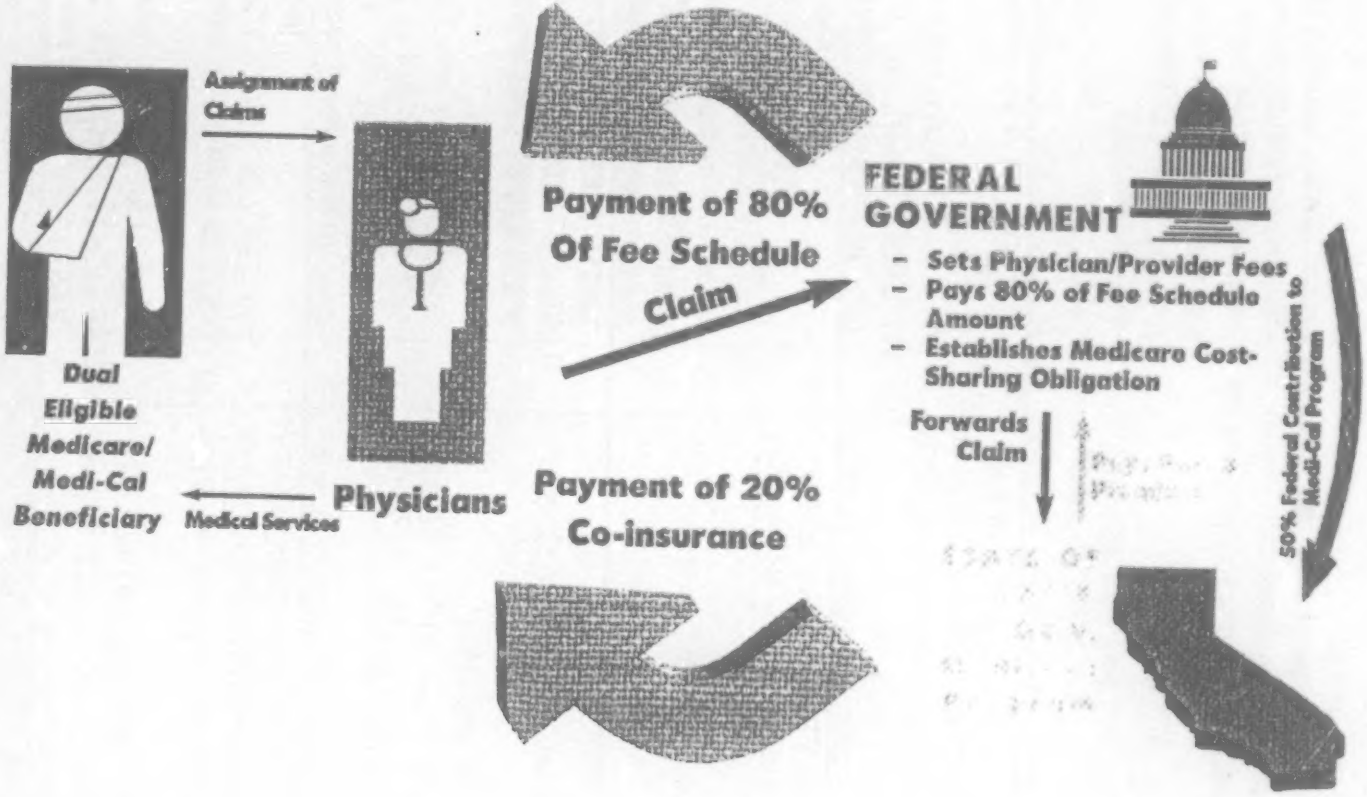
RETROACTIVE PROVISIONS AND CLARIFYING PROVISIONS CONTAINED WITHIN THE BALANCED BUDGET ACT OF 1997

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4331, 111 Stat. 395, 395-96 (1997). Amends: 42 U.S.C. §§1320a-7d(b)(2)(D); 1320a-7e(g)(3)(C); 1320a-7e(g)(5); 1320a-7(a)-(b); 1320a-7e(b); and 1320a-7a(i)(6).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 345 (stating that the amendments contained in subsections (a), (b), (d), and (e) would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4632, 111 Stat. 486 (1997). Amends: 42 U.S.C. §1395y(b)(2)(B).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 452 (declaring that clarification was necessary due to 1994 court decisions, which held that HCFA could not ignore insurance plan filing limits when seeking recovery for overpayments from such plans).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4714, 111 Stat. 509, 509-10 (1997). Amends: 42 U.S.C. §1396a(n).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 491 (stating that clarification was necessary due to court decisions that forced state Medicaid programs to reimburse Medicare providers at full Medicare rates for certain services).

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4722, 111 Stat. 514, 514-15 (1997). Amends: 42 U.S.C. §§1396b(w)(3); 1396b(b).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 496 (declaring that the amendments apply to taxes imposed before, on, or after the date of the Act's enactment).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4757, 111 Stat. 527 (1997). Amends: 42 U.S.C. §1315.	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 516 (declaring that the amendments apply to demonstration projects initially approved before, on, or after the date of the Act's enactment).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5001(h), 111 Stat. 577, 593 (1997). Amends: 42 U.S.C. §608.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5002, 111 Stat. 593, 593-94 (1997). Amends: 42 U.S.C. §604(d).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5003, 111 Stat. 594 (1997). Amends: 42 U.S.C. §607(c)(2)(D).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5004, 111 Stat. 594 (1997). Amends: 42 U.S.C. §609(a).	

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5301-5308, 111 Stat. 597, 597-603 (1997). Amends: 8 U.S.C. §§1612(a)(2); 1612(a)(2)(D)(i); 1612(a)(2)(A); 1612(b)(2); 1612(b)(2)(A); 1613; 1613(b)(1); 1622(b)(1); and 1641(b).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5401, 111 Stat. 603 (1997). Amends: 42 U.S.C. §503.	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 570 (stating that this provision was promulgated in response to a federal court decision and that the language applies to any period beginning before, on, or after the date of the Act's enactment).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5501-5518, 111 Stat. 606, 606-621 (1997). Amends: Portions of 42 U.S.C. §§602; 603; 604; 607; 608; 609; 611; 612; 613; 652; and 1308.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5525, 5528, 111 Stat. 624, 624-25 (1997). Amends: Section 105(b)(5) of the Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat. 853.	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 575 (stating that this amendment was necessary because at least one court reached conclusions regarding the provisions' meaning that were contrary to Congressional intent).

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5531-5557, 111 Stat. 625, 625-38 (1997). Amends: Portions of 42 U.S.C. §§608, 653, 654, 657, 663, 664, and 666.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5561-5574, 5582, 111 Stat. 638, 638-43 (1997). Amends: Portions of 8 U.S.C. §§1611-1613; 1621; 1622; 1631; 1641-1645; 42 U.S.C. §1383.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5612, 111 Stat. 647 (1997). Amends:29 U.S.C. §1169(a)(2)(B).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §8033, 111 Stat. 669 (1997). Amends: 38 U.S.C. §3726.	


Assignment of Claims
Payment of 80% Of Fee Schedule Claim
FEDERAL GOVERNMENT
- Sets Physician/Provider Fees
- Pays 80% of Fee Schedule Amount
- Establishes Medicare Cost-Sharing Obligation
Forwards Claim
50% Federal Contribution to Medi-Cal Program
Dual Eligible Medicare/ Medi-Cal Beneficiary
Medical Services
Physicians
Payment of 20% Co-insurance

[LOGO]

June E. O'Neill
Director

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
Washington, D.C. 20515

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimated of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified one provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Sincerely,

/s/ June E. O'Neill
JUNE E. O'NEILL

Enclosures

cc: Honorable John R. Kasich
Chairman, House Committee on the Budget

Honorable John M. Spratt, Jr.
Ranking Minority Member, House Committee on the Budget

Honorable Pete V. Domenici
Chairman, Senate Committee on the Budget

Honorable Frank R. Lautenberg
Ranking Minority Member, Senate Committee on the Budget

Honorable Bill Archer
Chairman, House Committee on Ways and Means

Honorable Charles B. Rangel
Ranking Minority Member, House Committee on Ways and Means

Honorable William V. Roth, Jr.
Chairman, Senate Committee on Finance

Honorable Daniel Patrick Moynihan
Ranking Minority Member, Senate Committee on Finance

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budget by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: the Taxpayer Relief Act of 1997 (H.R. 2014/Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $5 billion from increasing excise taxes on cigarettes and other tobacco products; and
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary

effects by title. The following pages give details by program and provision.

Table 4D.—Estimated Budgetary Impact of Subtitle H, Medicaid
(By fiscal year, in billions of dollars)

Medicaid rates for Medicare cost sharing for QMB and duly eligible beneficiaries:

By Fiscal year, in billions of dollars	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.6
Medicare Benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3

SOURCE: Congressional Budget Office

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Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payment rates are on average about 73 percent of Medicare payments rates. Limiting payment raters to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

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